State of Michigan
10/01/06 – 09/30/07
PriorityMedicare **Plan**
Summary of Benefits

The following information is provided as a summary of benefits available under your State of Michigan **Priority**Medicare plan. This summary is not intended as substitute for your Evidence of Coverage ("EOC"). It is not a binding contract. Limitations and exclusions apply to benefits as listed below.

This Summary of Benefits tells you some features of the plan. It doesn't list every service we cover, every limitation, or every exclusion. To get a complete list of our benefits, please call **Priority**Medicare and ask for the "Evidence of Coverage."

WHERE IS STATE OF MICHIGAN PRIORITYMedicare PLAN AVAILABLE?

The service area for this plan includes the following Michigan counties: Allegan, Antrim, Benzie, Crawford, Grand Traverse, Kalkaska, Kent,. Leelanau, Manistee, Muskegon, Montcalm, Oceana, Osceola, and Ottawa.

CAN I CHOOSE MY DOCTORS?

PriorityMedicare has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our **Priority**Medicare network. In some cases, you may also go to doctors outside of our **Priority**Medicare network. The health providers in our **Priority**Medicare network can change at any time. You can ask for a current **Priority**Medicare Provider Directory for an up-to-date list. Our number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN THE PRIORITYMedicare NETWORK?

If you choose to go to a doctor outside of our **Priority**Medicare network, you must pay for these services yourself. Neither **Priority**Medicare nor the Original Medicare Plan will pay for these services.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

PriorityMedicare has formed a network of pharmacies. You can use any pharmacy in our network. In some cases, you may also go to pharmacies outside of our network. The pharmacies in our network can change at any time. You can ask for a current Pharmacy Network List. Our number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A PHARMACY THAT'S NOT IN YOUR NETWORK?

If you go to a pharmacy that's not in our network, you might have to pay more for your prescriptions. You also might have to follow special rules before getting your prescription in order for the prescription to be covered under our plan. For more information, call the telephone number at the end of this introduction.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

PriorityMedicare covers both Medicare Part B prescription drugs and Part D prescription drugs.

DOES MY PLAN HAVE A PRESCRIPTION DRUG FORMULARY?

PriorityMedicare uses a formulary. A formulary is a preferred list of drugs selected to meet patient needs. The plan may periodically make changes to the formulary. If the formulary changes, affected enrollees will be notified, in writing, before the change is made. Contact **Priority**Medicare for details.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a benefit that your plan may offer. You may be identified to participate in a program designed for your specific health and pharmacy needs. It is recommended that you take full advantage of this covered benefit if you are selected. Contact **Priority**Medicare for more details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

The following outpatient prescription drugs may be covered under Medicare Part B. This may include, but is not limited to, the following types of drugs. Contact **Priority**Medicare for more details.

--Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.

--Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.

--Erythropoietin (Epoetin alpha or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.

--Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.

--Injectable Drugs: Most injectable drugs administered in your physician's office.

--Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by private insurance that paid as a primary payer to your Medicare Part A Coverage, in a Medicare-certified facility.

--Some Oral Cancer Drugs: If the same drug is available in injectable form.

--Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen. Inhalation and infusion drugs provided through DME.

WHAT HAPPENS IF I HAVE ADDITIONAL QUESTIONS?

Please call **Priority**Medicare for more information about this plan.

Visit us at priorityhealth.com or, call us.

Customer Service Hours:

Monday – Sunday 8:00 a.m. to 8:00 p.m. Eastern

Call (616) 464-8820 or toll-free 888 389-6648 for questions related to the State of Michigan **Priority**Medicare plan.
TTY/TDD 616 464-8485 or toll free 888 551-6761

For more information about Medicare, call 1 800 MEDICARE (1 800 633-4227)
TTY users should call 1 877 486-2048. You can call 24 hours a day, 7 days a week.

Or visit medicare.gov on the web.

If you have special needs, this document may be available in other formats.

State of Michigan
SUMMARY OF BENEFITS
PriorityMedicare
10/01/06 – 09/30/07

Prior Authorization: Your Primary Care Provider (PCP) will coordinate prior authorization of your services under the HMO Benefits of this plan. Prior authorization is required for all elective admissions, including behavioral health or substance abuse admissions. Other services requiring prior authorization are:

- Home health care & parenteral/enteral feedings
- Skilled nursing home facility and inpatient rehabilitation care
- Transplants and transplant evaluations
- Certain non-emergent outpatient radiology services: MRI, MRA, CT and PET scans
- Medical weight loss programs and surgery for obesity treatment
- Durable Medical Equipment (DME) over $1,000 and all DME rentals
- Prosthetics and orthotics over $1,000
- Infusion pumps (implantable and external)
- Non-emergent ambulance transportation
- Deep brain stimulation
- Automatic implantable cardioverter defibrillator (AICD)
- Radiofrequency catheter ablation for cardiac arrhythmia
- Stereotactic radiotherapy
- Nuclear cardiology
- Certain oral surgery services
- Certain injectable drugs from the Pharmacy Department
- All cosmetic and reconstructive surgery
- Experimental or investigational services
- Outpatient substance abuse care

BENEFITS	HMO BENEFITS
Deductibles	No deductibles.
Out-of-Pocket Maximums	Not applicable.
Maximum Individual Lifetime Benefit	Not applicable.
Other Important Information	You must elect a Primary Care Provider (PCP). You must coordinate all your care through your PCP and receive prior authorization from Priority Health when required in order to receive HMO Benefits.
	This plan replaces your current Medicare Part A & B Coverage. You must continue to pay the Medicare Part B premium each month.
Fee Schedules	Benefits are covered at the Medicare published fee schedule (or at Priority Health's negotiated fee schedules, when applicable).

BENEFITS	HMO BENEFITS
Preventive Care	
Routine Physical Examinations (Includes prostate screening for men and pelvic exams for women.)	You pay $10 for each primary care or specialist visit.
Colorectal Screening	100% Coverage.
Routine Pap Smears	100% Coverage.
Mammograms – Annual Screening	100% Coverage.
Bone Mass Measurement	100% Coverage.
Immunizations Includes influenza, pneumococcal and hepatitis B vaccines.	100% Coverage.
Outpatient Services	
Primary Care Provider (PCP Office visit)	$10 Copayment per visit
Allergy Services	100% coverage for injections and serum. Office visit Copayment may apply for testing.
Diagnostic Radiology and Lab Services	100% Coverage.
Imaging Services **Includes MRI, MRA, CT Scans, PET Scans and Nuclear Cardiac Studies,** Prior authorization required for non-emergent outpatient services. Contact plan for details.	100% Coverage.
Outpatient Surgery Authorization rules may apply for certain services. Contact plan for details.	100% Coverage.
Hemodialysis	100% Coverage.
Chiropractic Services	$10 Copayment per visit up to a maximum of 24 visits per contract year
Podiatry Services	100% Coverage for medically necessary foot care. Office Visit Copayment may apply. You pay 100% for routine care.
Medical Emergency and Urgent Care Services	
Emergency Care	$50 Copayment per visit (waived if admitted)
Ambulance Services	100% Coverage
Urgent Care Center	$10 Copayment per visit

BENEFITS	HMO BENEFITS
Inpatient Services	
Inpatient Hospital Care (semi-private room and intensive care, surgery and all related surgical services, ancillary services while inpatient, professional services)	100% Coverage.
Skilled Nursing, Subacute, Long-Term Acute, Inpatient Rehabilitation	100% Coverage. Maximum 730 days per Lifetime (combined benefit for all services)
Mental Health & Substance Abuse Services **All Outpatient Substance Abuse services must be approved in advance by Contacting the Behavioral Health Department at 616 464-8500 or 800 673-8043.**	
Inpatient Mental Health Services	100% Coverage. 100% Coverage. Maximum of 190 days in a Psychiatric Hospital in a lifetime.
Partial Hospitalization Mental Health Services Except in an emergency, prior authorization is required.	100% Coverage.
Outpatient Mental Health Services	$10 Copayment.
Substance Abuse Services	Inpatient Treatment for Alcohol and Drug Dependency covered in full. You pay $10 Copayment per visit for Outpatient Treatment
Family Planning/Infertility Services	
Infertility Counseling and treatment of underlying cause of infertility.	100% Coverage.
Vasectomy	100% Coverage when performed in a provider's office or when in connection with other covered inpatient or outpatient surgery.
Tubal Ligation	
Professional Fees	100% Coverage.
Outpatient	100% Coverage.
Inpatient	100% Coverage only when performed in connection with delivery or other covered inpatient surgery.

Other Services	
BENEFITS	**HMO BENEFITS**
Durable Medical Equipment	100% Coverage
Prosthetic & Orthotics	100% Coverage.
Outpatient Rehabilitation Services (Physical, Speech, Occupational and Cardiac Therapy)	You pay $10 for each physical, speech and occupational therapy visit, up to a maximum out-of-pocket amount of $200 per Contract Year. 100% Coverage for cardiac therapy.
Home Health Care	Covered in full.
Hospice Care	When you enroll in a Medicare-certified hospice, your hospice services are paid by Original Medicare. Care in a non-Medicare certified hospice is not covered.
Temporomandibular Joint Syndrome (TMJS) Treatment	80% Coverage.
Orthognathic Treatment	80% Coverage.
Port Wine Stains	80% Coverage.
Certain Surgeries – Professional Fees (Bariatric surgery, blepharoplasty of upper eyelids, breast reduction, panniculectomy, surgical treatment of male gynecomastia and procedures to correct obstructive sleep apnea.)	100% Coverage
Certain Oral Surgery Services Prior authorization applies.	100% Coverage.
Hearing Services	Covered for hearing exam and hearing aid (one per ear) once every 36 months. Maximum payable $500 per hearing aid
Vision Services	There is no Copayment for Medicare-covered eye wear (one pair of eyeglasses or contact lenses after cataract surgery). You pay $10 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye). You pay 100% for routine eye exams and glasses.

Additional Information	
Assignment of Benefits	If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

Prescription Drug Benefits	
Prescription Drugs This plan uses a formulary. A formulary is a preferred list of drugs selected to meet patient needs at a lower cost. If the formulary changes (and the change applies to you), you will be notified, in writing, before the change. For additional information about the drug formulary contact **Priority**Medicare. People who have low incomes, who live in long term care facilities, or who have access to Indian/Tribal/Urban (Indian Health Services) facilities may have different out-of-pocket drug costs. Your plan includes Coverage for Medicare Part D and Non-Part D drugs. For Non- Part D drugs, you will always pay the standard Copayment amount and this amount does not apply towards your $3,600 Copayment. There is no deductible. Certain prescription drugs will have maximum quantity limits. Contact plan for details. Your provider must get prior authorization from **Priority**Medicare for certain prescription drugs. Contact plan for details.	Before your yearly drug Copayments reach $3,600 for Medicare Part D Drugs, you pay the following for prescription drugs: **Retail Pharmacy:** • $ 5 for a one-month (31 day) supply of Generic drugs. • $ 10 for a one-month (31 day) supply of Brand drugs **Retail Pharmacy-With Extended Days Supply Contract.** • $ 15 for a three-month (90 day) supply of Generic drugs. • $ 30 for a three-month (90 day) supply of Brand drugs. **90 Day Medication List** • $ 5 for a three-month (90 day) supply of Generic drugs. • $ 10 for a three-month (90 day) supply of Brand drugs. **Mail Order Pharmacy** • $ 5 for a three-month (90 day) supply of Generic drugs. • $10 for a three-month (90 day) supply of Brand drugs. After your yearly out-of-pocket drug Copayments reach $3,600 for Medicare Part D Drugs, you pay as follows : **Retail Pharmacy:** • The greater of $2 or 5% coinsurance up to a maximum of $5 for generic drugs for a one month (31 day) supply • The greater of $5 or 5% coinsurance up to a maximum of $10 for brand drugs for a one month (31 day) supply. **Retail Pharmacy-With Extended Days Supply Contract.** • The greater of $2 or 5% coinsurance up to a maximum of $15 for generic drugs for a three month (90 day) supply • The greater of $5 or 5% coinsurance up to a maximum of $30 for brand drugs for a three month (90 day) supply **90 Day Medication List** • The greater of $2 or 5% coinsurance up to a maximum of $5 for generic drugs for a three month (90 day) supply • The greater of $5 or 5% coinsurance up to a maximum of $10 for brand drugs for a three month (90 day) supply **Mail Order Pharmacy** • The greater of $2 or 5% coinsurance up to a maximum of $5 for generic drugs for a three month (90 day) supply • The greater of $5 or 5% coinsurance up to a maximum of $10 for brand drugs for a three month (90 day) supply